



THE MENTAL AND PHYSICAL HEALTH OF RECENT IRAQI REFUGEES

IN SACRAMENTO, CALIFORNIA





**CLINICAL AND TRANSLATIONAL SCIENCE CENTER
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Following are the individuals comprising the project team, and the organizations they represent.

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EXECUTIVE SUMMARY

We are pleased to present the research results of the **Mental and Physical Health of Recent Iraqi Refugees in Sacramento, California** study, a collaboration between the University of California Davis and its community partners: Opening Doors, Inc. (ODI), a Sacramento-based agency which serves refugees and immigrants, and the Mesopotamia Organization (MESO), which is devoted to the support of Iraqi refugees in transition to new lives in Sacramento. This summary offers a brief overview of the study background, research rationale and purpose, our study team and refugee respondents, the process for interviewing recently arrived Iraqi refugees, key findings, and our study conclusions and recommendations. This study was funded by a pilot grant from the Clinical and Translational Science Center of UC Davis through the National Center for Research Resources, National Institutes of Health, grant number UL1 RR024146; by Molina Health of California and Health Net of California; and by a personal contribution from Dr. Rafael Amaro.

The project aimed to identify current health conditions of recent Sacramento area refugees from Iraq and to identify the challenges they encountered in accessing care for both physical and mental health conditions. The inspiration for our interview questions came from the lived experience of our Iraqi community partners and past health assessment studies of refugee populations. Mental health conditions such as depression, anxiety, and post-traumatic stress disorder (PTSD) are relatively common in individuals fleeing war-torn Iraq (Ghareeb, Ranard, & Tutunji, 2008), along with physical manifestations of psychological distress such as insomnia, headaches, and other physical ailments (El-Sayed & Galea, 2009; Inhorn & Serour, 2011; Orozovich & Ramos, 2010).

This interview-based study was guided by the principles of community-based participatory research (Minkler & Wallerstein, 2008), in which health researchers and community partners jointly plan and carry out all phases of a study. The Iraqi project staff from MESO were critical in all stages, setting an interview climate that made it clear to participants that they could talk freely about their health, without fear of stigma around particular conditions. The intermingling of physical and mental health conditions meant that we needed to ask questions in an open-ended format that balanced the need for sensitivity with the necessities of confidentiality and lack of bias. Interviews were conducted in Arabic by Iraqi interviewers who had been trained in qualitative

interviewing techniques, and who also helped analyze results within the framework of Iraqi culture and the specific context of recently arrived refugees. The thirty-four study participants, equally divided between men and women, had all lived in the Sacramento area between six months and three years at the time of interviews.

Our overall findings suggest that trauma was a key influence on both the mental and physical health of newly arrived Iraqi refugees. The collective nature of the ordeals experienced during the war was evidenced by the identification of family members and friends as key supports in overcoming health problems, along with faith in God. The biggest challenges to improving health centered on attempts to navigate the U.S. health system, which was experienced as convoluted, opaque, and unpredictable. The usual problems among underserved populations in the U.S. of receiving quality and efficacious health care were compounded in the Iraqi case by differing cultural expectations of the availability, affordability, and quality of care, and by differing assumptions about how best to communicate with health providers about accessing care and about mental health concerns.



KEY FINDINGS

- 1. Iraqi refugees found the U.S. health care system difficult to understand in four primary domains: (1) the referral system for specialized care, the length of time involved, and all the steps in between, (2) the separation of dental and vision services from the rest of healthcare, (3) the seemingly arbitrary nature of which conditions are covered by insurance and which are not, and (4) language barriers—either because English was still a new language, or because “medical language” was not comprehensible.**

Recommendation: There is growing interest in the role of health navigators, or advocates, to help underserved populations navigate the U.S. healthcare system. This is a role that could serve Iraqi refugees and possibly other Arabic-speaking refugees across the Sacramento area, with the support of refugee assistance agencies and cultural organizations. The health navigator role will be increasingly important with the advent of Affordable Care Act (ACA) opportunities being phased in over the next few years at both the national and state levels. There are numerous Iraqis in the region with health care backgrounds who currently serve in this role informally. However, making Arabic-speaking navigators a standard feature of health care—at the level of refugee and cultural support agencies, community clinics, and/or doctors’ offices—acknowledges the need of newcomers to improve their own health and move more quickly through an over-burdened health system, and to get information from someone who shares their language and culture.

In addition, there are few certified Arabic-speaking medical interpreters at the clinic level. Arabic interpreters can work hand-in-hand with health navigators to make sure that refugee patients feel confident that concerns, feelings and questions are communicated accurately and appropriately, and that they understand provider responses.

- 2. Mental health resources are not widely understood by Iraqi refugees coming to the U.S. In addition, the vast majority of participants in this study did not access mental health care, either out of lack of knowledge about options, unwillingness to bring up the subject of trauma with providers, or cultural and linguistic barriers to the understanding of how mental health is viewed and treated in the U.S.**

Recommendation: Again, the role and skills of trained Iraqi health navigators would go a long way in

explaining to newly arrived Iraqi refugees (1) the American concept of mental illness, particularly incorporating current efforts from the field of mental health to destigmatize mental illness and its treatment, (2) how traditional Iraqi ways of supporting individuals suffering from trauma can be integrated with American methods of psychotherapy and clinician-patient communication, and (3) the system surrounding mental health access, including costs, scheduling, referrals, etc. Organizations like MESO and ODI are key resources in identifying appropriate navigators, and in helping to define the most culturally and linguistically appropriate ways to offer and market mental health services. They should be assisted by mental health professionals familiar with Iraqi culture.

- 3. Primary care health providers know little about (1) Iraqi refugees, their health needs, and the effects of trauma on mental and physical health, and (2) refugees’ need for transparent communication of referral processes.**

Recommendation: A survey of providers, particularly those who regularly see Iraqi patients, would be useful to find out how they currently make referrals for this population and where there are gaps in their knowledge about the relevant Medi-Cal or insurance company procedures and regulations. Continuing education in the healthcare system features most difficult to understand by Iraqi refugees—mostly notably costs, referral processes, and mental health resources—should also be made available to providers. Training for healthcare providers in Iraqi culture, communication styles, beliefs and experience with doctors and other providers would also be useful.

- 4. Newly arrived refugees from Iraq know little about how their particular hurdles in accessing healthcare in a timely and culturally appropriate fashion coincide with the needs of other new refugees.**

Recommendation: Health care agencies, refugee support organizations, and academic institutions can be important resources in helping new refugees link with current efforts to make quality health care available to all. Present initiatives to connect newly eligible ACA recipients to upcoming insurance options or to advocate for the inclusion of refugees in the Low Income Health Plan (LIPH) should be further encouraged by collaborative efforts of all health care stakeholders.

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STUDY PURPOSE

The two goals of this qualitative health assessment were to identify current health conditions of recent Iraqi refugees in the Sacramento area and to identify the barriers to healthcare access faced by these refugees. We took into consideration not just their physical health, but also tried to understand the mental health of these individuals who lived in Iraq through the U.S. occupation and the end of Saddam Hussein's regime. The questions were modeled after past health assessment studies of refugee populations and followed an open-ended interview format which allowed participants to give detailed accounts of their health status before coming to the U.S. as well as after, and provided a foundation of inquiry for future research.

BACKGROUND

The United Nations High Commission on Refugees estimates that since 2006, over 4.7 million Iraqi refugees have fled their homes, with over 2 million displaced to countries outside of Iraq (USA for UNHCR, 2013). As of 2011, over 4 million Iraqis had been displaced worldwide (Ramos, 2011). Over 18,134 of these refugees resettled in the United States (Office of Refugee Resettlement, 2010), fleeing their home country to escape violence and religious or political persecution. In California, approximately 2,021 Iraqis refugees arrived between October 1, 2010 and September 30, 2011, making it the largest group of incoming refugees (31.37%) in the state during that period (California Department of Public Health, 2013).

When the California Department of Public Health (CDPH) conducted an assessment of refugees coming in to the state from October 1, 2009 to September 30, 2010, almost 50% (3,696) were Iraqi (Ramos, 2011). In terms of physical health, the top four physical conditions of these Iraqi refugees were latent tuberculosis infection (13.7%), hypertension (9%), dental caries (6.8%), and obesity (6.5%). A more in-depth look at Iraqi health in San Diego County, which has the highest concentration of Iraqi refugee resettlement in the United States, revealed a high level of chronic, noninfectious disease: 39.9% of adults over 40 had dyslipidemia, 29.6% of women had anemia, 24.6% of adults suffered from obesity, and 15.2% of adults over 18 had hypertension (Ramos & Orozovich, 2010). In addition, a study of a broader population of Arab immigrants showed that they are more likely to rate their health as fair or poor, particularly when they didn't speak English (Inhorn & Serour, 2011).

Initial mental health assessment questions asked at the time of CDPH refugee health screenings identified insomnia and adjustment-related stress as the most common mental health disorders (17% and 11% respectively) among Iraqi refugees in California (Orozovich & Ramos, 2010). This corresponds to larger studies of Iraqi refugees living in Syria from 2008-2011 which found that common mental health conditions were depression (89%), anxiety (82%), and post-traumatic stress disorder (PTSD) (68%) (Ghareeb, Ranard, & Tutunji, 2008). These conditions can be enduring and debilitating (Marshall, Schell, Elliott, Berthold, and Chun, 2005), and the combination of depression and a physical disorder frequently leads to greater disability than either condition alone (Gureje, 2009). A World Health Organization (WHO) study on

Approximately 2500 Iraqi immigrants and refugees live in Sacramento.

Psychological Problems in Primary Health Care found that patients with one or more mental disorders suffered higher levels of physical disability compared with patients receiving primary care for conditions unrelated to mental health (Ormel et al., 1994; Ormel, Petukhova, Von Korff, & Kessler 2009; Ustun & Satorius, 1995). In the case of Iraqi refugees, two or more mental health conditions often existed concurrently.

Iraqi refugee mental health is further compounded by long periods in host countries prior to resettlement, primarily in Turkey, Syria, Jordan, or Lebanon; by cross-cultural and acculturation challenges such as lack of employable skills and language issues once resettled in the U.S. (Ramos, 2011; Shannon et al., 2012); and by lower income status than Arab immigrants who have been settled in the U.S. for a period of years (Inhorn & Serour, 2011).

Studies on Iraqi refugee mental health have yielded conflicting results. A qualitative interview survey of recent Michigan refugees compared the distribution of mental health disorders and efficacy of treatment among Iraqi refugee and nonrefugee Arab immigrant populations (Jamil, Ventimiglia, Makki, and Arnetz, 2010). Results revealed an insignificant difference in diagnosis of mental health disorders between the two groups; both had high rates of major depression and

other anxiety disorders. They concluded that the impacts of being a refugee have less significance than previously thought on the development of these disorders. At the same time, there were better treatment outcomes for nonrefugee patients, which suggests that the effects of trauma experienced by refugees made recovery more difficult. The authors concluded that psychiatric treatment needed to be tailored to the specific needs of Iraqi refugees, whose symptoms were compounded by trauma and the stress of their new lifestyle, and that more research needed to be conducted on the specific history of trauma exposure experienced by these refugees. On the other hand, results of an assessment of three Iraqi refugee mental health studies suggested that they were more likely than other Arab immigrants to be diagnosed with PTSD and suffer accompanying physical ailments (El-Sayed & Galea, 2009; Inhorn & Serour, 2011).

While Iraqi refugees' perceived barriers to health care access have not been studied extensively in California, the San Diego study revealed that language, logistics and transportation, lack of insurance, cultural differences, and knowledge of the system were most commonly cited as barriers to health care access (Brouwer, 2007). This overlaps with a nation-wide study of barriers to health access by refugees in general in which 44 states identified lack of culturally sensitive services, mental health stigma, lack of trust, inadequate transportation, and communication and language breakdowns as major barriers to receiving adequate healthcare (Shannon et al., 2012).

Iraqi refugees in Sacramento

At the date of this report, approximately 2500 Iraqi immigrants and refugees live in Sacramento, the location for this study, according to the database of the Mesopotamia Organization (personal communication, Sarmed Ibrahim, March 27, 2013). For many of the refugees in this number, Sacramento was the first stop in the U.S. Others, however, arrived first to other states and then moved to Sacramento, primarily because of cheaper rents and housing.

Although there are now some health data on Iraqi refugees in California as a result of the 2010 CDPH report (Orozovich & Ramos, 2010; Ramos, 2011; Ramos & Orozovich, 2010), not enough is known about how Iraqi refugees in the Sacramento area navigate the U.S. healthcare system, and how mental and physical health issues coincide. For these reasons, two organizations in Northern California serving Iraqi refugees, the Mesopotamia Organization and Opening Doors, Inc. felt

that a more detailed description of the Iraqi refugee community's needs was necessary in order to improve their current health conditions.

Shannon et al.'s (2012) study of state refugee health coordinators' assessment of mental health screening practices showed that less than half the states ask refugees about war trauma or torture predating their arrival in the U.S. The CDPH Refugee Health Program provides health clinics in nine California counties, including Sacramento County, with funding to administer a health assessment for Iraqi refugees within the first 90 days of arrival. A mental health screening tool has been a part of this assessment, but the instrument was vaguely worded and varied from county to county. Mental health questions standardized across all counties have now been added to this instrument, and are currently being pilot-tested in Sacramento County: four relate to PTSD, two address generalized anxiety disorder, two relate to depression, eight relate to trauma, and one asks about persecution (Marisa Ramos, personal communication, January 14, 2013).

The purpose of this study is to establish a clear definition of the Sacramento area Iraqi refugee community's particular health needs, and to ascertain how the community views its current situation and relationship to the U.S. health system. The study will work towards not just documenting major health issues, but also identifying which particular health issues are believed to require the most attention. Other health needs assessments conducted with Iraqi refugees will be used as starting points to provide researchers for this study with interview protocols and models for conducting cross-cultural research (Ramos, 2010; Shoeb, Weinstein, & Mollica, 2007).

Refugees are qualified aliens under federal law and are eligible for full-scope Medi-Cal in California if they meet all eligibility requirements (i.e. couples with young children, elderly or disabled) (California Department of Health Care Services, 2013). Refugees who are ineligible for full scope Medi-Cal are eligible for Refugee Medical Assistance (RMA) for only 8 months from the date of U.S. admission. These include single adults or married couples without young children. However, in California as of January 1, 2014 under the expanded Medi-Cal or the Health Exchange components of the ACA, refugees will be eligible for both components to the same extent as U.S citizens (Refugee Health Technical Assistance Center, 2013).

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A community-university partnership

This study represented a collaboration between the UC Davis Clinical and Translational Science Center (CTSC), and community partners Opening Doors, Inc. and the Mesopotamia Organization. Partners from ODI included the Chief Executive Officer, an Iraqi refugee employee who served as an interviewer, and three ODI interns assisting at various stages of the study. Partners from MESO included the Director who served as project coordinator, three interviewers (one of whom also translated taped interviews from Arabic to English and helped coordinate research activities), one transcriber who transcribed audiotaped interviews, and one student trainee from a local community college who also served as a cultural resource.

UC Davis project personnel included the Principle Investigator, a psychiatrist with expertise in the connections between mental and physical health, and community-engaged research; the CTSC community engagement program manager, specializing in community-engaged research and qualitative research methods; and a post-doctoral fellow with expertise in Atlas-ti qualitative data software and training.

The study followed the principles of community-based participatory research (Minkler & Wallerstein, 2008), in which community partners play critical roles throughout the study, from the identification of research questions through data collection and analysis and dissemination of study findings. Our Iraqi partners from MESO and ODI staff members were invaluable partners at each step of the study.

STUDY SAMPLE

Selection criteria for the study required that participants must have arrived as refugees to the Sacramento area no earlier than January, 1, 2008, no later than six months before the start of the interviews, and be over the age of 18. Our sample was drawn from the Iraqi refugee databases maintained by ODI (169 individuals) and MESO (230 individuals) in Sacramento. From these combined sources, we conducted a purposeful sample of 34 individuals—17 males and 17 females—ranging broadly in age, health status, education, etc. Guiding this purposeful sampling frame was the principle of maximum variation (Patton, 2002) which states that common patterns emerging from great variation are essential in painting a picture of how a particular

phenomenon affects a population—in this case, the range of experiences with physical and mental health of recently arrived Iraqi refugees. This is where the collective community knowledge of MESO leadership and members was crucial. They were aware of the general health status of many of the newly arrived refugees, and could make sure that healthy individuals were included in the study as well as those who might have health problems. In keeping with qualitative data analysis methods, the interview process was halted when data saturation was attained and no new themes were discovered through analysis of interview transcripts (Bernard & Ryan, 2010).

Table 1 summarizes gender, ages, marital status, and educational levels of the participants:

Table 1. Profile of Iraqi Refugee Respondents

Sociodemographic Variables	Number of Responses (N=34)	Percentage of Responses (N=34)
Gender:		
Men	17	50%
Women	17	50%
Ages:		
20-29	2	6%
30-39	14	41%
40-49	8	24%
50-59	6	18%
60-69	2	6%
70-79	1	3%
80-89	1	3%
	Average: 44	
Marital Status:		
Married	26	76%
Single	2	6%
Widowed	5	15%
Divorced	1	3%
Education:		
College or Above	20	59%
High School	8	24%
Elementary-grade 9 "diploma"	4	12%
	2	6%
Number of people in household:	Average: 4 Range: 1-7	

METHODS

This study used qualitative interviewing as a means of eliciting respondents' behaviors, knowledge, and feelings about health issues upon immigrating to the United States and about accessing health care in the U.S. Qualitative methods were selected as most appropriate for an exploratory study of a population about which little is known—newly arrived Iraqi refugees in the Sacramento area—and for a topic which is potentially sensitive, in which care must be taken to let participants fully explain physical and mental health issues that emerged in the transition from Iraq and intermediary countries of refuge to the United States.

Questions for interview guides were standardized and open-ended; the exact wording and sequence of questions was determined in advance, and all interviewees were asked the same basic questions in the same order (Patton, 2002). Interview questions were based on a life history method modified from a study of Iraqi refugees in Dearborn, Michigan to explore the effects of trauma and PTSD among Iraqi refugees (Shoeb, Weinstein, & Mollica, 2007). Authors of the Dearborn study adapted the Harvard trauma questionnaire, developed to measure PTSD and associated trauma, along with brain injury, and posttraumatic symptoms, in a way that was adaptable to the particular cross-cultural context of Iraqi refugees. Their study sample was comprised of 60 Iraqi-born, Arabic speaking refugees arriving in the U.S. after the 1991 Gulf War. The resulting instrument captured not only the general categories of torture and trauma that characterize psychological stress in times of war, but also included such reactions as humiliation as corollaries of war trauma.

Three of our Iraqi study partners fluent in both Arabic and English were trained as interviewers for the study: two Iraqi men interviewed the 17 male study participants and one Iraqi woman interviewed the 17 females. These partners were either members of MESO or ODI employees, and had lived experience that was essential for study design as well as interview guide construction and culturally competent interviewing techniques. The interviewers received training from the CTSC community-engaged research consultant to the project. The training consisted of the theory behind open-ended interviewing, how to elicit authentic accounts from interviewees, and use of probing questions to stimulate rich responses without bias. Interviewers practiced interviewing in such a way that even though they were known to most of the respondents through MESO or

other community connections, study participants were assured of confidentiality around their responses to interview questions.

In addition to the demographic questions reported in Table 1, participants were asked to describe their general current health, as well as their health status before they came to the U.S.; where they receive health care currently, for what conditions, and how recently; attitudes about healthcare in the U.S. and reasons for positive or negative views; exposure to abuse or maltreatment in Iraq that could affect current health status; communication with healthcare personnel in the U.S.; and whether or not they had access to health insurance. Interviewers were trained in ways to put participants at ease, and questions that were deemed more sensitive, particularly those associated with mental health, were placed later in the interview guide. All interviews were audiotaped with participants' permission, and the study was approved by the UC Davis Institutional Review Board.

Data were analyzed through the qualitative data analysis software package Atlas-ti. Both community and academic team members were involved in identifying key themes across all 34 interviews.

FINDINGS

Results included both physical and mental health findings, along with information on access to healthcare in the Sacramento area.

Health Issues

Based on personal reporting from study participants, physical and mental health conditions varied greatly, but a number of similar conditions emerged, as displayed in **Table 2**.

Table 2. Common Health Problems

Condition	Number of Responses (N=34)	Percentage of Responses (N=34)
Mental Health	28	82%
Dental	20	59%
Vision	19	56%
Heart Conditions	13	38%
Chronic headaches	13	38%
Allergies	10	29%

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A majority—82%—said that they or a family member suffered from mental health issues directly related to the war in Iraq. Fifty-nine percent suffered from dental conditions, 56% had vision problems, 29% allergies, and 38% experienced heart conditions and high blood pressure. Thirty-eight percent also complained of headaches, stating that these headaches originated with the stress or anxiety of living conditions in Iraq which appeared around the same time as symptoms of depression. Three respondents—one male and two females—said they experienced no mental health issues.

Trauma and Health. Most men and women in the study reported instances of trauma resulting from the war (see **Table 3**).

Table 3. Number/Percentage of Participants Reporting Trauma

	Number of Responses	Percentage of Responses
Males (N=17)	14	82%
Females (N=17)	13	76%
Total (N=34)	27	79%

“The general situation...was not normal, some of my closest friends were killed at that time and I was waiting my turn. I lived in constant fear.”

Separating mental and physical health is always difficult, particularly when individuals have lived through a war. In addition, talking about mental health openly is often stigmatized, in Iraqi culture as well as many other cultures. Indeed, the Dearborn study reported that during Saddam Hussein’s regime, a stigma was perpetuated around the concept of mental illness, legitimized by psychiatrists at that time, which said that mental illness could not occur to a devout Muslim (Shoeb et al., 2007). Yet in our study, 82% of all respondents answered “yes” to questions about whether mental health was an issue early on in the interview (other prompts included heart disease, high blood pressure, dental, etc.), and 79% reported specific instances of trauma later on in the interview when

asked whether they had been exposed to maltreatment or abuse in Iraq, and if so, how this experience had affected their current health. It may have been that the interview environment, where the topic was health and confidentiality was assured, enabled respondents to speak more frankly than they would have in other social settings. One male respondent reported “I am troubled psychologically,” while another admitted that knowing many who died in Iraq affected him “psychologically, not physically.” Nonetheless, stigmatization was still in evidence: a male participant expressed the cultural inhibitions that prevented many Iraqis from seeking out treatment for mental health problems:

“Honestly...I do not like speaking about...personal problems in public. Whoever sees a psychiatrist is considered ‘crazy’, that is why we (Iraqis) are lagging behind and we have not seen a psychiatrist yet.”

Regardless of whether the traumatizing events reported happened to respondents personally or to others, the effects of trauma fell into a number of similar categories, as displayed in **Table 4**.

Table 4. Physical and Psychological Symptoms of Trauma

	Males (N=17)	Females (N=17)	Total (N=34)
Insomnia	6 (35%)	14 (82%)	20 (59%)
Depression	5 (29%)	10 (59%)	15 (44%)
Headaches	4 (24%)	10 (59%)	14 (41%)
Fear	4 (24%)	9 (53%)	13 (38%)
Shock	1 (6%)	5 (29%)	6 (18%)
Tension	3 (18%)	2 (12%)	5 (15%)
Anxiety	1 (6%)	2 (12%)	3 (9%)

Some of these conditions are similar to illnesses mentioned in the early part of the interview in response to questions about general health. And some, such as depression, fear, shock, anxiety, and tension, could arguably be considered either physical or mental health conditions, or both.

These findings reflect the findings from the Dearborn study, in which Iraqis used particular vocabulary to describe their “distress” in physical terms, including “headache, heart palpitations, and numbness,” in addition to a sense of nervousness or a feeling of a constriction of the chest, and/ or shortness of breath, originating from feelings of tension, financial, relational and/or emotional instability (Shoeb et al., 2007). Our participants additionally described somatic symptoms such as “pain all over the body,” “tension” in the head or jaw, or tension that resulted in “pain in the back and shoulder,” “pain and a sense of fear in the head,” “getting tired quickly,” or in one case, “temporary paralysis.”

Iraq’s tumultuous political situation took a toll on respondents’ families as well. One woman described in detail the murder of her husband as he was shot in front of her and their children, and how the murderers then attempted to kill her children. Her son was three and a half years old at the time and now frequently draws pictures of the bloody scene while looking at his father’s photograph. School counselors were assigned to help him psychologically in coping with these memories. Having to support her family in the U.S. as a single parent led eventually to what this respondent described as a nervous breakdown. As a result, her doctor ordered her to stay at home to take care of her health and apply for social security disability benefits.

Another participant recounted how his sons were abducted, imprisoned and beaten for sectarian reasons, and said that one of his sons still suffers from the effects of the wounds. Similarly, a female participant described how her son was brought home one early morning, beaten and injured. Emotional distress ensued for this participant, along with depression, and the triggering of epilepsy. These stories were common, reflecting layers of

both emotional and physical reactions to the trauma of living in a war zone.

Trauma as Collective Experience. Of the 34 participants, 41% of men and 24% of women described trauma in more collective terms rather than as a personal experience. As one respondent said,

“All Iraqis have witnessed cases of maltreatment and killing...why do you think we are here now in America? Psychologically it affected us all.”

A female respondent responded “obviously I am exhausted because I miss my relatives and everything here is new to us.” She then went on to explain the struggles with language barriers and financial needs for her family. Yet, even those who spoke of common suffering among all Iraqi refugees recounted personal experience. The woman who said that all Iraqis suffer psychological problems and physical illnesses said later in the interview, when asked about traumatic events back in Iraq, that she and her children were beaten and robbed, and as a result suffer from shock, insomnia, physical and emotional exhaustion, depression and fear, and are easily startled by loud sudden noises.

Support around mental health. Both males and females listed friends and family support as the most frequent support system for mental health, as displayed in **Table 5**.

Table 5. Sources of Support around Mental Health

	Males (N=17)	Females (N=17)	Total (N=34)
Friends/Family Members	14 (82%)	17 (100%)	31 (91%)
Religion/Faith/God	8 (47%)	14 (82%)	22 (65%)
Exercise/Sports	9 (53%)	6 (35%)	15 (44%)
Job/getting settled	5 (29%)	0	5 (15%)
Traditional Medicine	3 (18%)	2 (12%)	5 (15%)
School Counselors/doctors/professionals	1 (6%)	2 (12%)	3 (9%)
No one/Need Further Help	1 (6%)	1 (6%)	2 (6%)
Other (ie. crying, quarreling, “hope in future”)	5 (29%)	1 (6%)	6 (18%)

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Fourteen males (82%) and all females listed close family members or friends as confidants in times of mental distress. One individual said he and his wife talked together and cried together to deal with their grief, stating that crying is a very important way to release tension and other emotions, especially for men. Another male respondent on the opposite end of the emotional spectrum said he only talks to himself and quarrels with his family. Three men said they only confided in their wives, and the other four said they spoke to close family members or friends. Another man lamented that in his home, “depression is floating in the air.” Males also made comments about repressing anger and dealing with frustrations internally.

Of the women, three spoke only to their husbands and an additional four conversed only with a single confidant about these matters. One woman said she could talk to no one about her “psychological problems,” and another woman said that while she did not suffer from any mental health problems, she experienced insomnia, fear, mistrust, nervousness and nightmares. She further attributed the physical pain in her hand and shoulder to “all the tension.” While many respondents talked to friends, one respondent described the limitations of this outlet, again reflecting the collective nature of the trauma experience: “The problem is, I sense they have the same emotional problems I have.”

The second most common outlet for coping was turning to religion or God. Women listed “God/religion” as beneficial to their mental well-being almost twice as often as men, when prompted with the following list of sources for mental support: religion/faith, sports, exercise, traditional medicine, family support, friends, other. Of the 41% of men who listed religion as a source of mental well being and optimism, several males listed this as a strong need, including one who said he gets his “positive well-being first from God Almighty.”

Five men listed things that were not on the prompt list for mental health support, such as a job and financial stability, or home ownership. This is consistent with earlier studies of Iraqi refugee mental health challenges (Ramos, 2011; Shannon et al., 2012). A male participant said for his well-being he wished he and his wife could return to school and find a job to become financially secure and “move around.” Another expressed the thought that getting settled and finding a job that matched his college degree, age and health condition was what gave him a sense of well-being. Four of these

men also mentioned hope for the future or provision for their children’s futures as an important aspect of support. Females frequently mentioned that they continued to fear for the well-being of their children, and often used words like “exhausted” or described themselves as emotionally run-down.

Both males and females reported receiving little support from health professionals around mental health. When asked about sources of support and well-being, only three individuals (one male, two females) responded that they or a family member were able to see a health professional specifically regarding their mental health. One male said that he had been able to receive treatment through an organization in San Diego, but since his arrival in the Sacramento area was unable to find a similar resource. Another man said he did not suffer from mental health problems but that he might seek out a family friend who is a therapist in London if he wished to discuss his experiences in the future.

Access to Healthcare in the U.S.

To address the second goal of this assessment, participants were asked to rate their satisfaction with the healthcare they received since coming to the U.S. Thirty-four percent of participants answered positively, either “satisfied,” or “very satisfied.” Additionally, 24% identified their satisfaction level as “neutral,” or a 3 out of 5 on a Likert scale. This left 42% who were dissatisfied. Overall, the mean reported level of satisfaction from all respondents was 3.1.

Some responses appeared initially to be contradictory. For example, one respondent stated that he was “satisfied” with the health care he received; however, he followed this answer with a series of complaints about the cost of care, lack of coverage for needs like dental and vision, and lack of coverage for singles and married couples without children. Almost all participants, when prompted to elaborate on their satisfaction rating (positive or negative), gave criticisms of the system and expressed a need for improvement in the quality of care received and insurance coverage. **Table 6** displays major reasons for dissatisfaction:

Table 6. Reasons for Dissatisfaction with U.S. Healthcare

	Males (N=17)	Females (N=17)	Total (N=34)
Cost of healthcare	17 (100%)	17 (100%)	34 (100%)
Slowness of the system	12 (71%)	16 (94%)	28 (82%)
Condition/services not covered	12 (70%)	13 (76%)	25 (74%)
Long waits for treatment	9 (53%)	13 (76%)	22 (65%)
Emergency room treatment	7 (41%)	9 (53%)	16 (47%)
No dental coverage	5 (29%)	10 (59%)	15 (44%)
No vision coverage	2 (12%)	10 (59%)	12 (35%)
Perceived rudeness of providers	3 (18%)	9 (53%)	12 (35%)
Insurance problems	5 (29%)	6 (35%)	11 (32%)
Referral system ineffective	6 (35%)	5 (29%)	11 (32%)
Lack of clarity in system	6 (35%)	3 (18%)	9 (26%)
Personal health got worse	4 (24%)	3 (18%)	7 (21%)

Following is a discussion of some of the most persistent reasons for dissatisfaction with healthcare in the U.S.

Health Care Costs. The largest barrier to the desired level of healthcare and the leading cause for dissatisfaction with the U.S. health system was cost, mentioned by 100% of participants. The one respondent who answered that money was not an issue received adequate insurance coverage through Anthem Blue Cross (“better system than Medi-Cal”) as a benefit from his salaried job. This individual and his family were also some of the first Iraqi refugees to arrive in the Sacramento area after 2008, before many of the other study participants, giving him more time to acclimate to the culture and provide for himself and his family financially. Several respondents commented that the standard duration for refugee-status Medi-Cal coverage – eight months — did not give adequate time to find employment that provided insurance. As one participant explained:

“We need time to adjust with our new environment...we cannot have our college degrees evaluated until we could improve our language. Then we might get a job.”

This individual arrived in April of 2012—the most recent arrival in the study--and he along with several others agreed that if the duration were extended for Medi-Cal coverage, more Iraqis could successfully make the cultural transition and find adequate jobs to pay for health care themselves. While provisions of healthcare coverage through the Affordable Care Act will accelerate coverage for new refugees starting in 2014, the high costs of healthcare not covered by insurance was a big concern for many at the time this study was conducted.

Study participants learned about the differences in the U.S. between visiting a doctor as a patient with insurance through an employer and as a Medi-Cal patient. One respondent told of finally getting her mother, who was in great pain, to a doctor after waiting many months for the approval of a referral to see this physician. Upon arrival, the physician informed her that she never should have been referred to him, and that she must return to her primary care physician in order to repeat the referral process. He responded that he could not help them in any other way because their insurance was “just Medi-Cal.” This prompted the respondent to ask “why they [healthcare providers] do not respect us? It is because of them we arrived to this country as refugees, so why they treat us this way?” Throughout the interviews it became clear that many refugees understood that the problem of insurance coverage was not just an issue for Iraqis or refugees specifically, but that the current healthcare system created barriers for many people.

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Several respondents compared the cost of medications and medical procedures in the United States with the lower cost of healthcare in the countries in which they sought asylum before arriving in the U.S., when they were covered through the United Nations. Twenty-six percent said they continued to either send for medications or travel abroad to other countries to get their health needs met at a price they could afford. One reported, “In Egypt...we were capable [of] paying for the cost. Here in the U.S. health care is extremely expensive.” And another said, “I am dissatisfied, because they (primary care physicians) refuse to refer us to consultants. On the other hand we do not have enough money to pay because it costs a lot. That is why I went back to Iraq to seek treatment. In Iraq, it cost only \$10-\$15 to see a consultant...here in the U.S. it costs hundreds.” Several respondents commented on the fact that Iraqis are used to a free health care system. In the words of one, in Iraq “there is no such ‘health insurance,’ but anyone can go to the hospital even if he or she cannot afford the visit...” Another lamented that with health care through the United Nations, in host countries such as Syria or Egypt, “everything was available if we had health issues; there was a doctor who we used to know, and the cost was not much. In addition we were allowed vision and dental care. Same thing applies for people who needed surgeries, they were taken care of by the U.N.” This situation left some feeling frustrated:

“Doctors here [in the U.S.] only care about money; if the medical insurance pays well, then you are received for treatment and welcomed!”

Dental and vision care in particular were sought out elsewhere, because Medi-Cal covered neither adequately (although teeth extraction was covered). Fifty-six percent had vision problems which needed attention and 59% needed dental treatment. A male respondent needed much dental work, but since insurance only covered medication and tooth extraction, he had a number of teeth pulled rather than properly treated. He went on to describe his daughter’s dental situation as well, saying

that she has dental issues which should be covered by insurance, but since she was seen on referral, her insurance no longer covered the necessary procedures.

Waiting for Referrals. Many Iraqis found difficulties in getting referrals and seeing specialists to diagnose and prescribe for routine health needs that then became much more serious. A respondent described the case of his mother, who wanted to see a specialist about her high cholesterol. Her primary physician refused to refer her and this delay in desired care was perceived as resulting in a heart attack and subsequent open heart surgery. Another said that during the eight months he was covered he could not receive surgery for a pre-existing hernia condition. When he started choking, he sought help at a refugee clinic in downtown Sacramento, where he received surgery. This delay was accompanied by higher costs.

Sixteen participants (47%) complained of needing to visit the Emergency Room for healthcare because the wait to see a doctor was too long and/or their condition was too urgent. One participant reported that in eight months he was not able to meet with the specialists he desired because of the delay in the referral process with his primary care physician, so that the coverage was not as “useful” as it could have been. The consequence for poor coverage was that when it expired, those who could not afford to pay for their own health care experienced additional stress as they feared the constant possibility of getting sick and having medical insurance not adequately covering costs.

Cultural, linguistic, and general communication challenges. Similar to past research findings on this subject (El-Sayed & Galea, 2009; Inhorn & Serour, 2011; Ramos, 2011; Shannon et al., 2012; Wiking, Sundquist & Saleh-Stattin, 2013), language barriers and cultural differences were the second largest barrier to treatment. Forty-one percent said that they spoke English well enough to need no language assistance in a hospital or healthcare setting, and 24% (8) said they spoke some English, but still required additional assistance to understand their healthcare provider. Participants who required assistance received help either from a translator, family member, or friend. Eight participants mentioned friends or family members came to doctor visits with them and helped translate. One participant said that she can speak English fluently, but cannot understand her doctor’s “thick accent,” and this alone sometimes prevented clear communication with this physician. Three others said they spoke English almost fluently,

but did not understand many medical terms. One man brought a dictionary with him to appointments to solve this problem, and a female respondent said she wrote out phrases that confused her and discussed these terms with others until she understood the information. Yet many would like additional help.

Seven participants (21%) asked for a licensed interpreter from their healthcare provider. A male participant said that although he asked for a translator at the time of his appointment, he could not always get the help he needs. Providers often refused and told him to find his own, which he found unsatisfactory.

These communication gaps echo the findings of a study of refugee perspectives on communication barriers impeding the exploration of trauma histories in primary care (Shannon, O'Dougherty, & Mehta, 2012). When the cultural norm for doctor-patient communication is deference to the physician, and suffering from mental illness is viewed as a collective experience, refugees are not likely to bring up their own individual past traumas.

Communication was also compromised by the ways in which study participants were used to interacting with doctors, nurses, and other providers. Thirty-five percent of all participants discussed at length instances in which they experienced rudeness or seemingly uncooperative behavior from health professionals. One woman said she told her doctor that she recently developed pain in her shoulders that made sleeping difficult, and her doctor prescribed medication and told her that her health “[would] get worse gradually [as she ages] and there is no cure for that.” The participant went on to explain that even if a patient “should have cancer, the doctor should never relay health information in a way that would distress the patient psychologically.”

It should be noted that not all Iraqi immigrants were dissatisfied with the system. A couple of respondents distinguished between the quality of care received and the quality of insurance/health system. One female considered her health better in the United States because in Iraq she was “enormously weary, exhausted, fearful and horrified.” She could not sleep when she moved to the U.S. either, knowing that her children were apart from her in Iraq. These respondents felt that because the level of stress experienced while living in Iraq is less here, the quality of their health had increased. A male participant expressed his fervent hope:

“...this research [should] focus on all refugees from all around the globe coming to the U.S...they should get support and receive [a] better standard of living.”

NEW OPPORTUNITIES—THE AFFORDABLE CARE ACT (ACA)

Starting in 2014, refugees, as lawfully present immigrants, are eligible for the same protections and benefits as US citizens under the ACA (Refugee Health Technical Assistance Center, 2013). Refugees will be exempt from the five-year waiting period to receive Medicaid and to participate in the Children's Health Program (CHIP). Further details are as follows:

- If refugees' incomes are above 133% of the Federal Poverty Level (FPL) and they are under 65, they will be able to participate in health insurance exchanges, and some will qualify for premium tax credits for purchase of coverage if they are not insured by their employer. This includes adults without children under the age of 18.
- Refugees will be able to purchase affordable coverage through health insurance exchanges through premium and cost-sharing tax credits if their incomes are between 133% and 400% of the FPL.
- If refugees meet the above income criteria, they will be eligible for Medicaid/Medi-Cal after their eight months of initial Refugee Medical Assistance is exhausted (including childless adults as well as parents).
- Refugee children will continue to be eligible for the CHIP in California, including children up to age 26 who are aging out of the Unaccompanied Refugee Minors Program.

These opportunities will make a big difference in overcoming many of the obstacles mentioned by study participants, particularly for those who were not eligible for health coverage after their initial eight months of Refugee Medical Assistance aid through Medi-Cal. However, issues around negotiating access to health care through the lens of insurance requirements are unlikely

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to evaporate, and the intercultural communication issues that arise when the culture and language of the health care system are foreign will still need to be addressed.

DISCUSSION

Study results revealed strong connections between mental and physical health, as evidenced by the number of physical conditions brought up by participants in response to questions about health status in Iraq before immigration, and about effects of maltreatment or abuse in Iraq on current health. The reporting of insomnia, headaches, depression, anxiety, etc. are common to refugees fleeing war and the resulting dislocation and abuse (Ghareeb et al., 2008; Marshall et al., 2005). The collective nature of this experience, noted by a number of participants, is perhaps obvious—refugees are generally in a new country because of untenable situations in their countries of origin. This same collectivity is also a potential source of strength. The Dearborn report consulted with four psychiatrists in Iraq, and they affirmed their clients' resiliency, due to the network of healing provided through a mainly Muslim society based on family ties, honor and religion (Shoeb et al., 2007). However, the effect of stigma around mental illness lessens opportunities for collective healing, and must be accounted for in interventions which focus on the group nature of trauma.

The mental and physical health connection also has strong implications for treatment, as noted by advocates for the inclusion of psychiatry training in primary care physician residencies (Leigh, Stewart, & Mallios, 2006). The trend in clinical practice to increase provider skills in treating physical and mental health conditions simultaneously is not unique to the refugee health arena. However, our data make the case for combining mental and physical health treatment options for traumatized refugees—both individuals and families—who are navigating a new health system which they experience as bureaucratic, inconsistent, and illogical.

While roughly a third of participants were satisfied to some degree with healthcare in the U.S., they were still frustrated with the high cost of health care in a country without universal coverage, and with the institutional and structural hurdles encountered in a fragmented system in which insurance companies dictated conditions and amounts covered. The disassociation of dental and vision coverage in particular from healthcare seemed irrational. In addition, the procedures for getting referrals to specialists, characterized by long waits and

blurred communication channels, added to participant dissatisfaction when seeking healthcare for themselves or for family members. While it can be argued that all Americans who are seeking "safety net" healthcare can encounter such structural challenges, the refugee experience is compounded by language barriers and by the acculturation challenges that accompany moving to a new culture.

Even though the ACA will make available health insurance coverage to refugees starting in 2014, the intricacies of what is and is not covered through insurance will need clarification, as will the referral system to specialists. Equally as important, cultural norms as to how information is communicated around health, and recent trends that encourage patients to be proactive in their interactions with health professionals will need attention.

CONCLUSIONS AND RECOMMENDATIONS

The fact that many of the frustrations experienced by Iraqi refugees reflect the issues that have led to the broader call for American healthcare reform should not obscure the immediate needs of this population for access to more understandable and affordable paths to improving physical and mental health. Following are key conclusions and recommendations:

1. **Incoming Iraqi refugees need orientation to the American healthcare system in general—physical and mental health, as well as dental and vision care.**

Recommendation: Organizations serving refugees and immigrants should pursue funding for "navigators" to the U.S. healthcare system. These navigators would be a part of local Iraqi communities, and should have materials written in Arabic that explain regulations of how and when to access community clinics and other local providers around all aspects of health. In addition, navigators need to be able to explain to incoming refugees how to communicate with providers around such issues as costs and referrals, and who can serve as allies along the way. Identifying the most appropriate channels of communication to disseminate this information—face-to-face counseling, print messages, radio, TV, etc.—would also be an important step. Key allies in this support are local groups such as the Mesopotamia Organization and Opening Doors, Inc., which have the trust and credibility of refugees in the area and can provide valuable assistance with tailoring messages.

2. Language differences compromise effective communication for new refugees trying to communicate with healthcare providers.

Recommendation: Certified Arabic language medical interpreters should be provided for Iraqi and other Arabic-speaking patients in all clinical settings. Many respondents in this study used family members as interpreters, but this practice has many limitations in terms of accuracy, safety, confidentiality, and communication of feelings (Wiking, Sundquist & Saleh-Stattin, 2013). Trained interpreters, in concert with culturally competent healthcare navigators, are essential in communicating not only specific health conditions but also cultural nuances, health procedures and policies to newly arrived refugees.

3. Incoming Iraqi refugees will need assistance in determining eligibility for insurance under the provisions of the Affordable Care Act, starting in 2014.

Recommendation: The same navigators who assist refugees with the U.S. healthcare system in general will be able to help them make decisions about participation in health exchanges and other options available. Former refugees now residing as legal immigrants may also be eligible for ACA options, thus navigators may want to extend outreach efforts beyond new arrivals.

4. Incoming Iraqi refugees need orientation to the importance of acknowledging mental health issues, and also need resources in order to access care.

Recommendation: Navigators can also serve as guides to help “normalize” the need for mental health assistance and the effects of trauma on health when refugees first arrive in the U.S. from a war-torn country. Equally important, navigators should provide accurate information on mental health clinics that can serve incoming refugees, along with details of fee structures, whether or not mental health providers serve clients without insurance, and the collaborative nature of the doctor-patient relationship in the U.S. Again, the assistance of organizations like MESO and ODI in providing links with refugee assistance organizations and healthcare institutions is critical.

5. Primary health care providers, particularly those associated with health maintenance organizations, need a better understanding of the needs of Iraqi refugees for clarity around the referral process to specialists, in terms of costs and timeframe.

Recommendation: Local health clinics with many Iraqi refugee patients should be surveyed as to 1) knowledge and attitudes of providers around the legality of referrals, and 2) how the process for requesting referrals can be conveyed to refugee populations. Survey results can be used by continuing medical education providers to develop curricula and/or workshops on how to streamline referrals from primary care physicians to specialists in a timely, efficient, and understandable fashion.

6. Primary health care providers need a better understanding of how the traumas associated with war affect both mental and physical health, and how to broach the subject of mental health to Iraqi newcomers in a culturally appropriate fashion.

Recommendation: Continuing medical education efforts should also address the poorly understood connections between trauma and mental and physical health of not only Iraqi refugees, but also refugees coming from other war-torn countries. Additionally, providers would benefit from training on culturally sensitive ways to communicate around mental health in general to Iraqi refugees and on how to raise difficult issues around torture and other abuses that occur in war zones with Iraqi patients.

These recommendations are important to address, particularly as the number of refugees from Iraq and other Arab countries continues to grow in the Sacramento area and across the United States. We welcome comments on this report, along with further ideas as to how the health of Sacramento’s Iraqi and other Arabic-speaking refugees might be better addressed.

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